403.413: Prior-Authorization Requirements

(A) General Terms.

(1) Prior authorization must be obtained from the MassHealth agency as a prerequisite to payment for certain home health services and before services are provided to the member. Without such prior authorization, these services will not be paid by the MassHealth agency.

(2) Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

(3) Approvals for prior authorization specify the number of hours or visits for each service that are payable each calendar week and the duration of the prior-authorization period. The authorization is issued in the member's name and specifies frequency and duration of care for each service approved per calendar week.

(4) Prior authorization for continuous skilled nursing services may be approved for more than one home health provider or independent nurse, or both, provided that

(a) each provider is authorized only for a specified portion of the member's total hours; and

(b) the sum total of the hours approved over the duration of the approved period does not exceed what the MassHealth agency or its designee has determined to be medically necessary for the member.

(5) The home health agency must complete the Request and Justification form for all non-complex-care members who require more than two continuous hours of nursing. The Request and Justification form must be signed and dated by the member's physician and submitted to the MassHealth agency or its designee for review.

(6) The home health agency may initiate the prior-authorization process by telephone or electronically or by submitting a completed paper prior-authorization request form to the MassHealth agency or its designee. The home health agency must submit all prior-authorization requests in accordance with the MassHealth agency's billing instructions.

(7) If continuous skilled nursing services in excess of the authorized weekly amount are necessary, the home health agency must contact the MassHealth agency or its designee by telephone to request additional hours. The verbal request for additional hours must be followed up in writing within two calendar weeks of the verbal request.

(8) If there are unused hours of continuous skilled nursing services in a calendar week, they may be used at any time during the current authorization period.

~~(B) MassHealth Basic Members Not Enrolled in a Managed Care Organization.~~

~~(1) The home health agency must obtain from the MassHealth agency or its designee, as a prerequisite to payment, prior authorization for all nursing services for MassHealth Basic members who are not enrolled in a managed care organization (MCO). See 130 CMR 403.420(C) for service limitations of nursing care provided to MassHealth Basic members.~~

~~(2) The home health agency must submit to the MassHealth agency or its designee written physician's orders that identify the member's admitting diagnosis, frequency, and duration of nursing services, and a description of the intended nursing intervention.~~

~~(3) If authorized services need to be adjusted because the member's medical needs have changed, the home health agency must contact the MassHealth agency or its designee by telephone to request an adjustment to the prior authorization. Any verbal request for changes in service authorization must be followed up in writing to the MassHealth agency or its designee within two weeks of the date of the verbal request.~~

(B~~C~~) Complex-Care Members.

(1) The home health agency must obtain from the MassHealth agency or its designee, as a prerequisite for payment, prior authorization for all home health services defined in 130 CMR 403.403 provided to complex-care members.

(2) The home health agency must refer potential complex-care members to the MassHealth agency or its designee for a comprehensive needs assessment.

(3) If authorized services need to be adjusted because the complex-care member's medical needs have changed, the home health agency must contact the MassHealth agency or its designee by telephone to request an adjustment to the prior authorization.

(4) Any verbal request for changes in service authorization must be followed up in writing to the MassHealth agency or its designee within two weeks of the date of the verbal request.

(C~~D~~) Therapy Services for All Members for Whom Therapies Are a Covered Service. The home health agency must obtain prior authorization for the following services to eligible MassHealth members:

(1) more than 20 occupational-therapy or 20 physical-therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period; and

(2) more than 35 speech/language therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period.

(D~~E~~) MCO Members. For those members who are enrolled in a MassHealth-approved managed care organization (MCO), the home health agency must follow the authorization procedures of the MCO where applicable for home health services. For those MCO members whose nursing service needs are more than two hours in duration and are not covered by the MCO, the home health agency must comply with 130 CMR 403.000.

(E~~F~~) Screening. The home health agency must perform a screening of any member aged 22 and older who requires continuous skilled nursing services and refer members under the age of 22 who require continuous skilled nursing services to the MassHealth agency or its designee for case management.

(F~~G~~) Continuous Skilled Nursing Services. The home health agency must obtain prior authorization for continuous skilled nursing services from the MassHealth agency or its designee, as prerequisite for payment and before continuous skilled nursing services are provided to the member.

403.420: Nursing Services

(A) Conditions of Payment. Nursing services are payable only if all of the following conditions are met:

(1) there is a clearly identifiable, specific medical need for nursing services;

(2) the services are ordered by a physician for the member and are included in the physician's plan of care;

(3) the services require the skills of a registered nurse, or of a licensed practical nurse or licensed vocational nurse under the supervision of a registered nurse, in accordance with 130 CMR 403.420(B);

(4) the services are medically necessary to treat an illness or injury in accordance with 130 CMR 403.410(C); and

(5) prior authorization is obtained where required in compliance with 130 CMR 403.413.

(B) Clinical Criteria.

(1) A nursing service is a service that must be provided by a registered nurse, or by a licensed practical nurse or licensed vocational nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections, or insertion of catheters). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only a registered or licensed nurse can safely and effectively provide the service.

(3) When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a registered or licensed nurse, the service is not considered a nursing service, unless there is no one trained, able, and willing to provide it.

(4) Nursing services for the management and evaluation of a plan of care are medically necessary when only a registered or licensed nurse can ensure that essential care is effectively promoting the member's recovery, promoting medical safety, or avoiding deterioration.

(5) Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.

(6) A member's need for nursing care is based solely on his or her unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(C) Service Limitations for MassHealth ~~Basic~~ CarePlus Members. Nursing visits provided by a home health agency are covered for a MassHealth ~~Basic~~ CarePlus member only when the following conditions and all other requirements of 130 CMR 403.000 et seq. are met:

(1) such care is provided following an acute inpatient hospitalization;

(2) such care is intended to help resolve an identified short-term (for example, 14 days) skilled-nursing need directly related to the member's acute hospitalization; and

(3) for members other than those enrolled in an MCO, the home health agency obtains prior authorization as a prerequisite to payment for nursing visits following a referral from the hospital directing the member's discharge.

403.421: Home Health Aide Services

(A) Conditions of Payment. Home health aide services are payable only if all of the following conditions are met:

(1) the member has a medically predictable recurring need for nursing services or therapy services;

(2) the frequency and duration of the home health aide services must be ordered by the physician and must be included in the physician's plan of care for the member;

(3) the services are medically necessary to provide personal care to the member, to maintain the member's health, or to facilitate treatment of the member's injury or illness; and

(4) prior authorization, where applicable, has been obtained where required in compliance with 130 CMR 403.413.

(B) Payable Home Health Aide Services. Payable home health aide services include, but are not limited to

(1) personal-care services;

(2) simple dressing changes that do not require the skills of a registered or licensed nurse;

(3) assistance with medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse;

(4) assistance with activities that are directly supportive of skilled therapy services; and

(5) routine care of prosthetic and orthotic devices.

(C) Nonpayable Home Health Aide Services. The MassHealth agency does not pay for

~~(1) home health aide services provided to MassHealth Basic members; or~~

~~(2)~~ homemaker, respite, and chore services provided to any MassHealth member.

(D) Incidental Services. When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the definition of a home health aide service (for example, light cleaning, preparing a meal, removing trash, or shopping). However, the purpose of a home health aide visit must not be to provide these incidental services, since they are not health-related services.